UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM,	§	
PLAINTIFFS	§	
	§	
v.	§	CIVIL ACTION NO.
	§	4:14-cv-3253
	§	JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE.	§	
DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 22

Patient Account: 20005972-517
Med. Rec. No.: (0150)564760Q
Patient Name: HINOJOSA, ALBERT
Age: 44 YRS *DOB:* 05/22/68 *Sex:* M *Race:* S
Admitting Dr.: OUTSIDE TDCJ
Attending Dr.: OUTSIDE TDCJ
Date / Time Admitted : 08/30/12 0846
Copies to :

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University of Texas Medical Branch
Galveston, Texas 77555-0543
(409) 772-1238
Fax (409) 772-5683
Pathology Report

180 2681

FINAL AUTOPSY REPORT

Autopsy Office (409)772-2859

Autopsy No.: AU-12-00188

AUTOPSY INFORMATION:

Occupation: INMATE Birthplace: UNKNOWN Residence: TEXAS
Date/Time of Death: 8/29/12 1:50 Date/Time of Autopsy: 8/30/12
Pathologist/Resident: CAMPBELL/VAN DELLEN Service: TDC CONTRACT
Restriction: NONE

***
The on-line version of the final autopsy report is abbreviated. If you would like a copy of the complete final report, or if you have any questions regarding this report, please contact the Autopsy Division Office, (409)772-2858.
***

FINAL AUTOPSY DIAGNOSIS

I.	Body as a whole: Clinical history of morbid obesity, seizure of unknown origin, and hyperkalemia	C2
II.	Heart: Cardiomegaly. Weight: 552 g; hypertrophy	A4
	A. Right ventricle: Dilatation	A4
	B. Lungs, bilateral: Congestion	A4
III.	Other findings:	
	A. Kidneys: Early diabetic changes including glomerular hypertrophy	A3
	B. Biliary system: Cystic duct occlusion by white/tan stone, 1.5 x 1.5 cm	A3
	1. Gallbladder lumen: 5 tan/white stones, 1.5 x 1.5 cm	A3
	2. Gallbladder wall: Diffuse thickening	A3
	C. Liver: Macrosteatosis	A3
	D. Thyroid: 1 x 1 cm adenoma	A5

****TYPE: Anatomic(A) or Clinical(C) Diagnosis.*
*IMPORTANCE: 1-immediate cause of death (COD); 2-underlying COD; 3-contributory COD; 4-concomitant, significant; 5-incidental ****

Continued...

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CLINICAL SUMMARY:

The decedent was a 44 year-old morbidly obese Hispanic male incarcerated at TDCJ, with a history of hypertension, hyperlipidemia, diabetes type II, paranoid schizophrenia, and depression. On August 29th, 2012, he was found in his cell having a seizure. He was transported to Christus Spohn hospital in Beeville, TX, and upon arrival to the emergency department, his heart rate was 175 bpm. Although his core temperature was not recorded in the emergency room records, his skin was noted to be hot, and the ambient temperature in the cell around the time of the seizure was recorded to be 92 degrees Fahrenheit. He was pronounced deceased on August 29th, 2012 at 0150 hours. A complete autopsy was performed on August 30, 2012.

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11/07/12

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Autopsy No.: AU-12-00188

GROSS DESCRIPTION:

CLOTHING AND PERSONAL EFFECTS: None

THERAPEUTIC INTERVENTION:
1. Endotracheal tube
2. Anterior thorax: 5 EKG pads
3. Anterior thorax: 2 defibrillator pads
4. Left upper extremity: 1 defibrillator pad
5. Right upper extremity: 1 defibrillator pad
6. Left lower extremity: 1 defibrillator pad
7. Right lower extremity: 1 defibrillator pad
8. Right antecubital fossa area: Intravenous catheter
9. Right hand, second digit: Bandaid covering puncture wound
10. Left upper extremity: Puncture wound with surrounding ecchymosis
11. Left hand, second digit: Pulse oximeter
12. Left hand, dorsum: Puncture wound with surrounding edema and ecchymosis

EXTERNAL EXAMINATION: The body, identified by name on the left wrist band, is that of a 54-year-old obese Hispanic male, with a body length of 184 cm. Rigor mortis is present in the mandible and all four extremities. The skin is intact, with red/pink and slightly blanchable lividity present in the face, anterior and posterior neck, and posterior thorax. The head and face are shaven with black stubble present on the scalp and chin. There is black hair on the supraorbital ridges. The calvarium is symmetric and intact to palpation and the scalp is intact. The cornea are cloudy, and the conjunctivae are injected, with focal hemorrhage in the right lateral sclera. The irides are brown and the pupils are 0.4 cm bilaterally. Dentition is poor.

The following marks and scars are present:
" Anterior thorax: 1 x 1 cm abrasion
" Bilateral upper extremities: White striae
" Abdomen, bilateral hypochondriac and lumbar regions: White striae
" Left patellar region: 2 white scars, 2 x 2 cm each
" Left anteromedial leg: White scar, 2 x 1.5 cm
" Left anterior ankle: 2 red scabs, 1 x 2 cm each
" Right anteromedial leg: 2 white scars, 1 x 0.2 cm, and 1 x 1 cm, respectively

INTERNAL EXAMINATION: The body is opened using a Y-shaped incision from the xiphoid process to reveal a 6.0 cm panniculus and the thoracic organs in the correct anatomic position. There is mediastinal soft tissue hemorrhage present, and fractures of the left 2nd through 5th ribs.

SEROUS CAVITIES: The pericardial space contains 50 mL of serosanguinous fluid. The right and left pleural spaces each contain 20 mL serosanguinous fluid. There is no appreciable accumulation of fluid in the peritoneal space.

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GROSS DESCRIPTION:

CARDIOVASCULAR SYSTEM: The heart weighs 552 g (normal 270-360 g). The left ventricular wall is 1.5 cm (normal 1.0-1.8 cm) in thickness at the junction of the posterior papillary muscle and free wall. The right ventricle is dilated, and 0.4 cm (normal 0.25-0.3 cm) thick, measured 2cm below the pulmonic valve annulus, anteriorly. The cardiac valves are unremarkable. Valve circumferences measured on the fresh heart are: tricuspid valve 10.5 cm (normal 12-13 cm), mitral valve 11 cm (normal 10.5-11.5 cm), aortic valve 8.5 cm (normal 7.7 cm-8 cm), pulmonic valve 8.8 cm (normal 8.5-9 cm). The foramen ovale is closed. The endocardium is smooth, and the majority of the anterior surface of the heart is covered with epicardial fat.

No significant stenosis is observed in the coronary arteries. The posterior circulation is right dominant. The thoracic and abdominal aorta and major branches are intact. There is no embolus or thrombus observed in the pulmonary artery. There is moderate fatty streaking of the infrarenal aorta. The celiac, superior and inferior mesenteric, renal, and iliac arteries are normal. The superior and inferior vena cavae and portal vein are normal.

RESPIRATORY SYSTEM: The neck presents an intact hyoid bone as well as thyroid and cricoid cartilages. The larynx is comprised of unremarkable vocal cords and folds, appearing widely patent without foreign material, and is lined by smooth, glistening membrane. The epiglottis is a characteristic plate-like structure, and grossly unremarkable. The trachea is in the midline and mucosa is mildly congested. The right lung weighs 550 g and the left 460 g. Both lungs have a pink surface with occasional anthracotic pigment, and serial sectioning reveals a congested parenchyma. There is a thick brown mucoid substance in the bilateral bronchi.

GASTROINTESTINAL SYSTEM: The tongue has a finely granular surface and is unremarkable. The pharynx and esophagus are intact with diffusely congested mucosa. The stomach is intact with unremarkable mucosa and contains approximately 50 mL of brown-green fluid. There are patchy areas of mucosal congestion in the small and large bowel, which are otherwise unremarkable. The appendix is present and grossly normal.

The liver weighs 2,100 g (normal 1400-1900 g). The surface is smooth and glistening, with patchy areas of pale discoloration. Serial slicing reveals a diffusely smooth and pink parenchyma with patchy areas of pale discoloration.

The gallbladder wall is tan/pink and thickened. The lumen contains 200 mL of clear, white fluid, and 5 tan/white stones, each measuring 1.5 x 1.5 cm. The cystic duct is occluded with a 1.5 x 1.5 cm tan/white gallstone.

GENITOURINARY SYSTEM: The renal cortical surfaces have patchy areas of

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GROSS DESCRIPTION:

congestion and pitting. The capsules do not strip with ease. The right and left kidneys each weigh 200 g. There is congestion at the cortico-medullary junction. The right cortex and medulla are 0.8 cm and 1.5 cm, respectively, and the left cortex and medulla are 0.8 cm and 1.0 cm, respectively. The renal columns of Bertin extend between the well demarcated pyramids and appear unremarkable. The medulla presents normal renal pyramids with unremarkable papillae. No calculi are observed. The renal arteries and veins are unremarkable.

The ureters are of normal caliber lying in their course within the retro peritoneum and are probe-patent into the urinary bladder. The urinary bladder mucosa is unremarkable.

Prostate: The prostate is tan in color, and appears normal in size. Serial slicing reveals a uniformly smooth, tan surface.

Testes: The right and left testes weigh 34 g and 32 g, respectively (normal 20-25 g). The tunicae albugineae are tan/white, smooth and glistening. The cut surfaces are tan/yellow, and the tubules string with ease.

HEMATOPOIETIC SYSTEM: The spleen weighs 250g (normal 125-195 g). The cut surface reveals a dark red, congested parenchyma.

ENDOCRINE SYSTEM: The thyroid gland weighs 20 g (normal 10-22 g), presenting two well-defined lobes with connecting isthmus and a beefy brown cut-surface, and a tan, well-circumscribed nodule which measures 1 x 1 cm. The parathyroids are identified and submitted for histological examination. The right and left adrenal glands weigh 10.8 g and 8 g, respectively. There is a 2.5 x 2 cm multinodular mass in the left adrenal gland cortex. The adrenal glands are otherwise unremarkable

CENTRAL NERVOUS SYSTEM: The scalp is intact without contusions or lacerations. There is hyperostosis frontalis internal observed in the calvarium, which is otherwise unremarkable. The brain weighs 1,470 g (normal 1200-1400 g), and is fixed in formalin for later examination by a neuropathologist.

SPINAL CORD: The spinal cord is fixed and formalin for later examination by a neuropathologist.

Toxicologic Tests:
Postmortem blood obtained from femoral vein was sent for toxicologic testing to Aegis Sciences Corporation Laboratory, Nashville, TN.
Positive results are summarized in the next section.

MVD/da

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Pathology Report

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Autopsy No.: AU-12-00188

GROSS DESCRIPTION:
10/26/12

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FINAL AUTOPSY REPORT

Autopsy Office (409)772-2859

Autopsy No.: AU-12-00188

MICROSCOPIC DESCRIPTION:

Note: All slides are stained with H&E unless otherwise specified.
NPC = No Pathologic change
(autolysis) after a diagnosis means that post mortem decomposition compromised the assessment

Adrenal gland, right, slide 1: NPC

Adrenal gland, left, slide 2: NPC

Thyroid, slide 3: Follicular adenoma

Parathyroid, slide 4: NPC

Thymus, slide 5: NPC

Testes, slide 6: Active spermatogenesis; focal tubular sclerosis

Heart, slides 7-10: Hypertrophy

Kidneys, slide 11: Probably early diabetic changes including glomerular hypertrophy; mild atherosclerosis. Autolysis.

Lungs, slides 12 and 13: NPC

Liver, slide 14: Macrosteatosis

Spleen, slide 15: NPC

Esophagus, slide 16: NPC

Stomach, slide 17: NPC

Pancreas, slide 18: NPC

Duodenum, slide 19: NPC

Colon, slide 20: NPC (autolysis)

Rectum, slide 21: NPC (autolysis)

Prostate, slide 22: Focal prostatitis

Vertebra, slide 23: > 50% cellularity, NPC

Toxicologic Results:

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FINAL AUTOPSY REPORT

Autopsy Office (409)772-2859

Autopsy No.: AU-12-00188

MICROSCOPIC DESCRIPTION:

Tests performed included: Aegis #'s 40599 Profile-ME Comprehensive, 70511 - Confirmation Amphetamines, 70592 - Atypical Antidepressant Conf, and 71470 - Confirmation Lidocaine. Fluoxetine analysis was performed at NMS Labs, Willow Grove, PA.

Fluoxetine level: 530 ng/mL (0.530 ug/mL)
Desmethylfluoxetine (Norfluoxetine): 360 ng/mL (0.360 ug/mL)
reporting threshhold for both is 50 ng/mL

Lidocaine level: 644 ng/mL with 250 ng/mL reporting threshhold.
All other analytes were negative.

The original report from Aegis Labs is filed in the Autopsy Division, UTMB Galveston.

MVD/da
11/07/12

Patient Name: HINOJOSA, ALBERT
Patient Location: AUTOPSY
Room/Bed:
Printed Date / Time: 11/15/12 - 1310

Patient Account: 20005972-517
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Pathology Report

NEUROPATHOLOGY CONSULTATION

Neuropath Office (409)772-2859

Autopsy No.: AU-12-00188

CLINICAL HISTORY:

The decedent was a 44 year old morbidly obese Hispanic male incarcerated at TDCJ, with a history of hypertension, hyperlipidemia, diabetes type II, paranoid schizophrenia, and depression. On August 29th, 2012, he was found in his cell having a seizure and was transported to Christus Spohn Hospital in Beeville, TX. He was pronounced deceased on August 29th, 2012 at 0150 hours. A complete autopsy was performed on August 30, 2012. The cause of death is undetermined by the gross autopsy, and further studies, including microscopic and toxicologic examinations, are pending. The manner of death is undetermined.

PATHOLOGIST/RESIDENT: CAMPBELL/VAN DELLEN

GROSS DESCRIPTION:

Submitted for neuropathologic examination are brain (unfixed weight 1470 g), convexity and posterior fossa dura, spinal cord with spinal dura (length 35 cm, conus medullaris and filum terminale present), and pituitary gland.

The dura is grossly unremarkable. There is no evidence of jaundice staining. There is no evidence of acute hemorrhages, subdural membranes, or masses. There is no evidence of thrombosis of the superior sagittal sinus.

External examination reveals the brain to be intact and normally developed with mild fibrosis of the convexity leptomeninges. There is no evidence of arachnoid hemorrhage, exudate, focal softening, discoloration, atrophy, swelling or herniation. The major cerebral arteries do not have significant atherosclerosis. The circle of Willis has a normal pattern, and no aneurysms or other malformations are identified.

The hemispheres are sliced coronally, revealing normal anatomic development and normal cerebral ventricles. The cortical ribbon is normal in thickness and appearance, the cerebral white matter is normally myelinated, and the gray-white junction is distinct throughout. No focal lesions are identified in the hemispheres.

The brainstem and cerebellum are separated through the cerebellar peduncles, and the cerebellum is sliced sagittally and the brainstem transversely. Both structures are normally developed, and have normal pigmentation of substantia nigra and locus ceruleus. There is no evidence of focal lesions.

The spinal dura is opened anteriorly, revealing no evidence of extradural, subdural or arachnoid hemorrhage. The spinal cord is sliced transversely at 0.5 to 1 cm intervals, revealing normal development and no evidence of parenchymal lesions.

The pituitary gland is intact and normally developed, without external

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NEUROPATHOLOGY CONSULTATION

Neuropath Office (409)772-2859

Autopsy No.: AU-12-00188

GROSS DESCRIPTION:

hemorrhages or other lesions. The horizontal cut surface reveals normal anterior and posterior lobes, and no evidence of internal lesions.

Photographs made during gross brain examination: none.

DICTATED BY: GERALD A. CAMPBELL, M.D., PATHOLOGIST
11/14/12

SECTIONS TAKEN:

B1: Pituitary gland; B2: Right frontal, area 8; B3: Right basal ganglia; B4: Left hippocampus; B5: Left cerebellum.

FINAL DIAGNOSES:

A. Brain and cranial dura (weight 1470 g):
1. Leptomeninges, convexity: Mild fibrosis
2. Basal ganglia: Small vessel disease, mild (see comment)

B. Spinal cord and spinal dura (35 cm caudal segment): No gross abnormalities

C. Pituitary gland: No gross or microscopic abnormalities

COMMENTS:

Small vessel disease in this context refers to medial thickening and/or hyalinization of small parenchymal arteries and arterioles, and in some cases increased adventitial collagen of small veins and venules.

***
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GERALD A. CAMPBELL, M.D., PATHOLOGIST
Division of Neuropathology .

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(Electronic Signature).

Gross: 11/14/12
Final: 11/14/12

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CLINICOPATHOLOGIC CORRELATION:

The decedent was found to be having a seizure of unknown origin. Some of the predisposing factors of seizures, which may be implicated in this case, include hyperthermia and certain medications such as antipsychotics. The ambient temperature of 92 degrees Fahrenheit, along with a clinical history of morbid obesity and the use of antipsychotic medication, are all factors which may have predisposed him to hyperthermia and/or seizure activity.

Hyperthermia may occur when the body produces an excessive amount of heat, or cannot adequately dissipate heat, such as when exposed to extreme environmental temperatures. As the core temperature increases, there is an increase in metabolic rate and oxygen consumption. Enzymes are affected by changes in temperature, as these proteins require a certain temperature and pH range beyond which they begin to denature. Injury to the cell membrane occurs, and tissues begin to leak potassium into the circulatory system. The electrical conduction system of the heart is exquisitely sensitive to potassium, and a serum level above the upper limit of normal, such as was seen in this case, can potentially induce a cardiac arrhythmia. Hyperthermia and seizure activity can both cause a dangerous increase in heart rate, and lead to cardiac arrhythmias, which was likely the mechanism of death in this case.

Toxicologic analysis revealed levels of fluoxetine (Prozac) and its active metabolite norfluoxetine of 0.530 and 0.360 ug/mL, respectively. No other antipsychotic drugs were detected. Blood levels in patients receiving therapeutic doses of fluoxetine have been reported in the ranges of 0.09 to 0.473 (fluoxetine) and 0.18 to 0.466 (norfluoxetine) ug/mL [1], [2]. The levels reported for this decedent are consistent with therapeutic doses and not close to the lowest levels reported in fatal overdoses (1.3 and 0.9 ug/mL respectively). The mild elevation of fluoxetine over the reported therapeutic range may be due to hemoconcentration or post-mortem redistribution. Therapeutic levels of fluoxetine are not specifically associated with either seizures or increased susceptability to environmental hyperthermia. The measured lidocaine level is relatively low, and is consistent with use as a local anesthetic.

In summary, this decedent had significant predisposing conditions including morbid obesity, diabetes with renal disease, and hypertension with cardiomegaly. The clinical history and record of hyperkalemia suggest environmental hyperthermia leading to fatal cardiac arrythmia. The body temperature prior to death was not recorded and the autopsy can not provide direct evidence of hyperthermia or arrythmia, however other potential causes of death with this history and presentation such as pulmonary thromboembolism and myocardial ischemia due to significant atherosclerotic coronary disease were ruled out. Anatomic brain lesions that might cause seizures were also absent. Toxicologic test results do not suggest drug overdose or poisoning.

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CLINICOPATHOLOGIC CORRELATION:

Based on the above considerations it is our opinion that this decedent was vulnerable to the effects of environmental hyperthermia due to pre-existing natural disease, and likely suffered a seizure followed by fatal cardiac arrythmia as a result. The manner of death is natural.

References:
[1] Basalt RC, Cravey RH. Disposition of Toxic Drugs and Chemicals in Man, 4th ed. (1995) Foster City, CA: Chemical Toxicology Institute, pp. 336-338.
[2] Wynek CL, et al. Drug and chemical blood level data 2001. Forensic Sci Int. (2001) 122:107-123.

MVD/da
11/07/12

GERALD A. CAMPBELL, M.D., PATHOLOGIST (Electronic Signature)

11/14/12

END OF REPORT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM,	§	
PLAINTIFFS	§	
	§	
v.	§	CIVIL ACTION NO.
	§	4:14-cv-3253
	§	JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE.	§	
DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 23

TDCJ MORTALITY COMMITTEE WORKSHEET

DEMOGRAPHIC INFORMATION			
Offender Name: Roberts, William Perry	**TDCJ#:** 1717525	**Date of Incarceration:** 6/24/2011	
DOB: 10/21/1949	**DOD:** 7/29/2011	**Time of Death:** 03:17 AM	**Autopsy?:** YES ☒ NO ☐
Age: 61	**Race:** White	**Sex:** Male	**Unit of Assignment:** Byrd

MEDICAL SUMMARY & EVENTS OF DEATH				
Was the death Expected?			YES ☐	NO ☐
Cause of death:	Natural ☐	Accident ☐	Homicide ☐	Suicide ☐

Chronic Diagnoses: HTN, DM, sz d/o

Chronic Medications:

Other Relevant Medical History: Noted on intake on 6/24/11 to have HTN, DM, and seizure disorder. He was started on propranolol, amlodipine, KCl, enalapril, oxybutynin, and pravastatin with discontinuation of gabapentin and another medication per verbal order from a PA.

Summary of Events Leading Up to Death: He was seen the following day on 6/25/11 because "he looked like he might faint. The offender complained of weakness. The Headache/Dizziness nursing protocol was utilized and a physician was called. FSBS was 293 and he was noted to not be on diabetic medication. Urine dipstick was done but results were not documented. He was given 500 cc of NS iv and started on metformin. He was scheduled for follow up two days later on 6/27/11. Later that evening, he complained of dizziness and fell. After the fall, he complained of neck pain and was subsequently transferred to an outside ER.

The offender was seen on 6/26/11 complaining of weakness and nausea. He had a temperature of 101.7 and pulse of 121. He was noted to appear flushed, has FSBS of 303, and urine dipstick demonstrated 2+ glucose, 80 ketones, and small protein. A nurse practioner gave verbal orders for 1000 mg of metformin, 8 u of insulin, to push fluids while in clinic, and to follow up with provider on the following day. He was seen later that day for seizure activity. New orders received from NP but not clear what was ordered by documentation.

On 6/27/11, he was seen by PA who noted previous seizure activity, allergy to dilantin, and started tegretol 400mg per day. He was brought to medical later that day for seizure and given tegretol by LVN and sent back to cell.

He was seen again on 6/28/11 for multiple seizures and plan was to move him to a 24 hr unit. He then reported suicidal ideation and was cleared for crisis management. Upon assessment by mental health, he was sent to a 24hr medical facility due to seizures and low suicide risk.

His intake physical was done on 6/29/11 and no complaints were noted. Orders for trasfer to 24 hr unit and labs were written.

On 6/30/11 he was sent to the unit ER for weakness and confusion. The patient reported difficulty complying with medications and reported he thought he needed a benzodiazepine. He was given his scheduled meds and sent to cell.

On 7/2/11 he was cleared for segregation so that he could have a lower bunk due to seizure activity.

On 7/5/11 the offender was seen as a walk-in in clinic by an LVN for seizure activity reported by security. Psychiatric symptoms protocol and headache protocols were both utilized. He complained of insomnia and and difficulty eating. He reported that he believed he was not on the correct medications. A provider was notified who ordered CBC, comprehensive metabolic panel, tegretol level, EKG, provider consult, and MH evaluation in am.

On 7/5/11, the offender was found "passed out in cell". He reportedly gained consciousness within 2-5 minutes and was able to walk to medical for assessment. The examining RN documented that the offender requested hospitalization for fear of self harm and reported difficulty eating and sleeping. Although the nurse reported the offender's thought processes were "unrealistic", he was released to security with plans to follow up in the am.

He was seen by a physician on 7/6/11 who documented the offender had 6 episodes of seizure-like activity in the last 7 days. The offender had a history of dilantin causing rash and had previously been started on tegretol. A seizure was witnessed by the physician who felt the seizure was likely due to alcohol withdrawal. Speech was noted to be slow, but post-ictal state was ruled out. The offender was started on dilantin with benadryl, advised to keep appointment with mental health for the following day, and given restrictions on HSM-18. On 7/7/11, he was seen by mental health. He was noted to significant psychomotor retardation and intermittent confusion and reported depression and insomnia. He was started on risperdol and nortriptyline for presumed Bipolar I disorder depressed with psychosis. Possible Korsakoff's syndrome was considered.

Summary of Events the Day of Death: Found unresponsive and febrile in cell. He was transported to outside hospital but was pronounced dead on arrival.

Offender Name: Roberts, William Perry	**TDCJ#:** 1717525

DEATH AND AUTOPSY DETAILS

AUTOPSY FINDINGS (if performed): atherosclerosis of coronary arteries, aorta, and iliac arteries; marked dilation of both ventricles, arterionephrosclerosis of both kidneys, and congestion of both lungs.

If the Autopsy was performed, then state the documented Cause of Death:

CAUSE OF DEATH

ENTER THE DISEASE, INJURIES OR COMPLICATIONS THAT CAUSED THE DEATH, DO NOT ENTER THE MODE OF DYING SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE ON EACH LINE.

(final disease or condition resulting in death)

A. **Pneumonia per death certificate**

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (disease or injury that initiated events resulting in Death) LAST

B. **Anoxic brain injury per death certificate**

C.

D.

E.

Committee Consensus Cause of Death: Unknown
possible sudden cardiac death (heart disease or medication), diabetic ketoacidosis, seizure, Wernike-Korsekoff encephalopathy, hypoglycemia, suicide by drug overdose, malignant neuroleptic syndrome, environmental induced hyperthermia

Offender Name: Roberts, William Perry			**TDCJ#:** 1717525	
QUALITY OF CARE ISSUES				
1. Does the Reviewer recommend this case be referred to Peer Review?			YES ☒	NO ☐
If yes, check which of the following:	Physician ☒	Dental ☐	Nurse (RN / LVN) ☐	
Allied Mental Health Professionals ☐	Other ☐	If other, describe:		
2. Should this case be referred to Utilization Review for Morbidity Case Management Review?			YES ☐	NO ☒
3. Should this case be referred to System Leadership Council for review of systemic issues that affect health care?			YES ☐	NO ☒
4. Should this case be referred for a review of security or facility issues that affected health care?			YES ☐	NO ☒
5. List reason(s) for all above referral(s): Poor management of seizure disorder				
6. Was the death summary completed in the medical record?			YES ☐	NO ☒
7a. If autopsy was authorized, was the final autopsy report completed by the time of review?	N/A ☐		YES ☐	NO ☒
7b. If no, what is the presumed cause of death and list any unresolved concerns? Unknown cause of death. See Committee consensus.				
8. Was the patient suitable to be considered for Medically Recommended Intensive Supervision (MRIS)?			YES ☐	NO ☒
9. Were there any inconsistencies between clinical history and autopsy? Explain: Cause of death not yet evident, micro and toxicology not yet available.	N/A ☐		YES ☒	NO ☐

Reviewer's Name: R.Williams **Date: 12/7/2011**

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM,	§	
PLAINTIFFS	§	
	§	
v.	§	CIVIL ACTION NO.
	§	4:14-cv-3253
	§	JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE.	§	
DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 24

From: Robert Williams
To: Dr. Danny Adams
Sent: 8/9/2011 12:48:09 PM
Subject: Re: details of possible heat-related issue

Thank you for your efforts.

----- Original Message -----
From: "Adams, Charles D." [cdadams@utmb.edu]
Sent: 08/09/2011 05:44 PM GMT
To: "Wright, Gary G." <ggwright@UTMB.EDU>; "Smock, Stephen R." <srsmock@utmb.edu>; Kathryn Buskirk; Robert Williams; "Penn, Joseph" <jopenn@UTMB.EDU>; "Shelton, Billy W." <bwshelto@UTMB.EDU>
Cc: "Moore, Christina J." <cjmoore@UTMB.EDU>; "Adams, Glenda M." <gmadams@utmb.edu>; "Biscoe, Paul I." <pibiscoe@UTMB.EDU>
Subject: RE: details of possible heat-related issue

Good Morning,

I was at Hodge this morning to discuss the recent deaths, suspicious for being heat-related. I visited the housing area involved, J bldg. All of the involved patients were housed on the second level, which I am told is several degrees warmer that the first level, and that seemed to be the case, to me, at 10 am. Two of the cells involved faced the west and I am told that they could get pretty warm late in the afternoon . The patients had access to cold water up until 10 pm, when the cell doors are secured. After this, they still had access to water via their in-cell sinks. The involved patients were relatively young, 41-53 years old, all took pm doses of their psych meds (compliance is being verified), all events occurred between 0300 and 0615. This last information was a little surprising to me. I was expecting them to be in the hotter times of the afternoon or even midday.

Meds involved were: Pt. 1- Thorazine 200 mg q/pm, Tegretol 200 mg q/pm

Pt. 2- Thorazine 200 mg q/pm, Celexa 40 mg q/pm

Pt. 3 - Cogentin 2 mg q/pm, Celexa 40 mg.q/pm and Respiradol 3 mg q/pm

The unit is currently reviewing all patients on psychtropics to insure that all have appropriate heat restrictions noted on the HSM-18.

I am told that no one has any restrictions as to outdoor recreation, which might be modified in the summer months. I don't know if we can verify whether or not they recreated outdoors recently.

I am also verifying any work assignments and hours involved, what they actually did and did they report for work in the 1-2 days before they died.

I appreciate Ms. Moore's help with this and look forward to her findings on medication compliance and work assignments.

Danny

Charles D. (Danny) Adams, MD, MPH
Senior Medical Director- Outpatient Division
UTMB-CMC

From: Wright, Gary G.
Sent: Tuesday, August 09, 2011 11:54 AM
To: Adams, Charles D.; Smock, Stephen R.
Cc: Wright, Gary G.
Subject: FW: details of possible heat-related issue

My limited research thus far has produced the following:

1.Swanson, Adam #1638679 Hodge 41y/o male Medical Cars 2

last physical 6/3/10 Meds:cogentin,celexa,risperdal Restrictions : III. 9 and 25 since 10/13/2010

2.Cook, Charles #1457546 Hodge 53y/o male Medical Cars 0

last physical 1/28/11 Meds:tegretol ,thorazine Rest:III. 19,20,21,25 since 11/3/10

3.Webb,Robert #1569761 Hodge 50y/omale Medical Cars 1

last physical 5/20/11 Meds:thorazine,celexa,prilosec Rest: III.15,16,18 since 10/28/10

4.Meyers,Thomas #680515 Coffield 46y/o male Medical Cars 2

last tests 7/28/2011 (TSH elevated) EKG 6/30/11-normal had not taken meds x 1 week
Meds:vasotec,synthroid,pravachol,risperdal Rest:III.19,20,21 since 7/18/11

5.Togonidze,Alexander #1578039 Michael 44 y/o male Medical Cars 3

last tests 7/7/11 (HgbA1c-6.7)
Meds:tegretol,tenormin,vasotec,pamelor,prilosec,sudafed,pravachol,glucophage

Rest:II.B2 III.12,19,20,21.

Additionally, I currently have the medication compliance records for the three patients at Hodge and working on the others. In general these compliance records indicate extremely poor compliance. I will bring them by the office for you to ponder. The above represents a summarization of the facts as we currently know them. Will review other data as time and review of records permit. Anything in particular let me know.

Gary

Dr. Gary Wright, DO
NE District Medical Director
Ph# 903-928-2311 ext. 1330
ggwright@utmb.edu<mailto:ggwright@utmb.edu>

From: Adams, Charles D.
Sent: Tuesday, August 09, 2011 7:39 AM
To: Wright, Gary G.; Smock, Stephen R.
Subject: RE: details of possible heat-related issue

That is my understanding. I don't believe they ever consider shutting down or limiting recreation.

Danny

Charles D. (Danny) Adams, MD, MPH
Senior Medical Director- Outpatient Division
UTMB-CMC

From: Wright, Gary G.
Sent: Tuesday, August 09, 2011 7:09 AM
To: Adams, Charles D.; Smock, Stephen R.
Subject: RE: details of possible heat-related issue

Am in process of having all patients that have either died or been shipped out with elevated temperatures forwarded to me. Should have this information within the next 24 hours at which time I will research each patient regarding his HSM-18 RESTRICTION for heat restriction. And as I understand the HSM-18 restrictions, the avoidance of heat restriction is applicable to work related activities and nothing more. Please correct me if I am incorrect in this regard. Will forward you these names and the fruit of my research as soon as available.

Gary

Dr. Gary Wright, DO

NE District Medical Director
Ph# 903-928-2311 ext. 1330
ggwright@utmb.edu<mailto:ggwright@utmb.edu>

From: Adams, Charles D.
Sent: Monday, August 08, 2011 4:27 PM
To: Wright, Gary G.
Subject: FW: details of possible heat-related issue

Charles D. (Danny) Adams, MD, MPH
Senior Medical Director- Outpatient Division
UTMB-CMC

From: Kathryn.Buskirk@tdcj.state.tx.us [Kathryn.Buskirk@tdcj.state.tx.us]
Sent: Monday, August 08, 2011 4:19 PM
To: Adams, Charles D.
Subject: details of possible heat-related issue

Per our phone call, there have been four unexpected deaths in the last six days.
All four offenders were taking antipsychotics.
Three of the four offenders had elevated temperatures immediately prior to the time of death (104.6 axil., 105.4 axil., and 107.9 axil.). The fourth offender was found dead, so there were no vital signs available.
Three of the offenders were at the Hodge unit. One offender was at the Coffield unit.
Only two of the four offenders had heat restrictions.

I appreciate your help with looking into this issue.

(The offenders' names and TDCJ #s will be sent in another email for confidentiality.)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

STEPHEN McCOLLUM, and SANDRA McCOLLUM, individually, and STEPHANIE KINGREY, individually and as independent administrator of the Estate of LARRY GENE McCOLLUM,	§	
PLAINTIFFS	§	
	§	
v.	§	CIVIL ACTION NO.
	§	4:14-cv-3253
	§	JURY DEMAND
BRAD LIVINGSTON, JEFF PRINGLE, RICHARD CLARK, KAREN TATE, SANDREA SANDERS, ROBERT EASON, the UNIVERSITY OF TEXAS MEDICAL BRANCH and the TEXAS DEPARTMENT OF CRIMINAL JUSTICE.	§	
DEFENDANTS	§	

Plaintiffs' Consolidated Summary Judgment Response Appendix

EXHIBIT 23

From: Marjorie Davis on behalf of Kathryn Buskirk
To: Lannette Linthicum
Sent: 6/14/2013 10:32:15 AM
Subject: Possible Heat-Related Deaths 2011- Report
Attachments: 9-2-2011.PDF

Kathryn Buskirk, M.D., CMD
Director of Quality Monitoring and Compliance
Health Services Division
Texas Department of Criminal Justice
(936)437-4008

Possible Heat-Related Deaths 2011
9-2-11

Name	TDCJ Number	Unit of Assignment	Date	Autopsy Location	Autopsy Information
McCollum, Larry	1721640	Hutchins	July 22, 2011	DALLAS Cty ME	Not available yet
Meyers, Thomas	680515	Coffield	August 2, 2011	UTMB	Provisional: "pending final autopsy"
Black, Shearry	1497435	Hobby	August 3, 2011	UTMB	Provisional: "pending final autopsy"
Webb, Robert	1569761	Hodge	August 4, 2011	UTMB	Provisional: "sudden cardiac death"
Martone, Michael	1395315	Huntsville	August 8, 2011	Harris Cty ME	Not available yet
Togonidze, Alexander	1578039	Michael	August 8, 2011	UTMB	Provisional: "hyperthermia"
Cook, Charles	1457546	Hodge	August 8, 2011	UTMB	Provisional: "hyperthermia"
Marcus, Kelly	1128380	Connally	August 12, 2011	UTMB	Provisional: "pending final autopsy"
James, Kenneth	1726849	Gurney	August 13, 2011	UTMB	Provisional: "hyperthermia"
Jones, Jeffery	1728537	Gurney	August 20, 2011	UTMB	Provisional: "pending final autopsy"
Alvarado, Daniel	1517660	Beto	August 20, 2011	UTMB	Provisional: "pending final autopsy"
Jackson, Curtis	1623790	Estelle	August 20, 2011	UTMB	Provisional: "coronary heart disease?"
Johnson, Emma	1673927	Murray	August 25, 2011	UTMB	Not available yet
Boggus, James	1593395	Gurney	September 1, 2011	UTMB	Not available yet